

# **EXHIBIT 7**

**AUTHORIZATION FOR RELEASE  
OF WORKERS' COMPENSATION AWARD**

TO:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

This document will authorize you to furnish a copy of any workers' compensation award or requests for permanent total or permanent partial disability benefits made since January 1, 2009 concerning the following claimant \_\_\_\_\_

\_\_\_\_\_  
whose date of birth is \_\_\_\_\_ and whose last four digits of social security number is \_\_XXX-XX-\_\_\_\_\_.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records:

Name: \_\_\_\_\_

Law Firm: \_\_\_\_\_

Address: \_\_\_\_\_

This authorization does not authorize you to disclose anything other than any worker's compensation award or requests for permanent total or permanent partial disability benefits made since January 1, 2009 to anyone.

This authorization is not valid unless the record requestor named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined award of worker's compensation after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

Date: \_\_\_\_\_

\_\_\_\_\_  
Claimant/Personal Representative Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness Signature